

A. 2. - Every item of information should be tabularly reported. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

JAN 25 1929

41930

1. PLACE OF DEATH

County Osage
Township Bedford
City..... (No..... St..... Ward)

Registration District No. 639
Primary Registration District No. 5848

File No.....
Registered No.....

2. FULL NAME

Mylianda Henrietta Cramer

(a) Residence No. St. Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/11 1928

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

17. I HEREBY CERTIFY, That I attended deceased from 12/10 1928, to 12/11 1928, that I last saw her alive on 12/11 1928, and the death occurred, on the date stated above, at 3:05 a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/8/1913

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>13</u>	<u>2</u>	<u>3</u>	

Cerebro Spinal Meningitis

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

Influenza (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Influenza (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Osage Co mo
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER Wm F. Cramer

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Osage co
(STATE OR COUNTRY)

WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Clara E. Apel

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) Howard W. Hanson, M. D.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) mo
(STATE OR COUNTRY)

, 19 (Address) Pershing mo

14. INFORMANT W. F. Cramer
(Address) monson mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15. FILED..... 19..... REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Good Hope Cemetery DATE OF BURIAL 12-12 1928

20. UNDERTAKER Arnold Sturment ADDRESS Merion mo

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Oregon Registration District No. 639 File No.
 Township Benilton Primary Registration District No. 5848 Registered No.
 City (No.) St. Ward

2. FULL NAME

Myrinda Henrietta Crames
 (a) Residence No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 1-9-29 L.E. Sanders REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/11 19 28

17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw him alive on 19..... and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Epidemic meningococcal meningitis
W. H. H. H. H.
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B. - If the CAUSE OF DEATH is not properly classified, Exact statement of OCCUPATION must be given. AGE should be stated. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESENTED.

SUPPLEMENTARY

S-41930